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No. 97-520

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,

v.

IT CORPORATION, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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REPLY BRIEF OF PETITIONER

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REPLY BRIEF OF PETITIONER

INTRODUCTION

Petitioner General American Life Insurance Company ("General American") respectfully submits this Reply Brief which addresses four points newly raised by the Brief in Opposition by IT Corporation ("IT Corp.").

As shown below, IT Corp.'s newly raised points simply reconfirm that the Ninth Circuit's decision not only sharply clashes with ERISA[1] and its regulations, but creates far more problems in a key area of ERISA plan administration than it solves. Unless this Court intervenes, the increasingly heavy burden of litigation in this area—15 recent published court of appeals decisions referred to in the petition, with several dozen published district court decisions—will only swell even more due to the conflicts presented by this latest decision. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. 1754, 1758 (1997), it is vital that this Court resolve the pivotal issue of ERISA fiduciary status presented by this case. This issue not only touches every pension and welfare plan in the country, but has caused a vast amount of litigation and created a sharp split now affecting eight of the circuits.

A few introductory words are necessary because the Brief in Opposition, in raising new points including a discussion of an agency relationship, uses some extremely "loose language" in its factual sections. Several brief examples will suffice.

IT Corp. tells the Court that the Administrative Services Agreement ("ASA") between IT Corp. and General American stated the *Plan* was to open a bank account "for General American's use in making payments as Gen-

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[1] ERISA is the acronym for the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001, *et seq.*

eral American *saw fit*. (Appendix to Petition pp. 25a-26a 'Section 2'.)." (Brief in Opposition ("Opp.") at 2) (emphasis added). A look at the citation shows, however, that *IT Corp.* was to open a bank account to be used by General American *"to make payments pursuant to [the ASA] and the Plan."* (emphasis added).

Pursuant to section 5 of the ASA, General American, "acting . . . as agent of [IT Corp.]" (App. to petition at 25a), was to perform certain administrative and ministerial activities including initial claims-processng and the forwarding of payment checks to *IT Corp.* for distribution. (Opp., App. at A1-A2). The Plan established by IT Corp. contained the written verification of eligibility requirements that General American was required to follow. Under the Plan, a late enrollee was excluded from eligibility if "unable to carry on the duties and activities of a person of similar age." (App. to petition at 19a). In case of payment to an ineligible person, the ASA provided that the right to initiate court proceedings lay with *IT Corp.*, not General American. (Opp., App. at A5-A6). IT Corp.'s assertion that the parties agree General American wrongfully disposed of $600,000 in plan assets is not true. (Opp. at 19-20). The issue of fiduciary status was the sole question before the courts below, the amount of payments and the question of whether General American, in paying claims, acted on instructions of IT Corp., were not before the courts below.

Contrary to IT Corp.'s suggestion (Opp. at 3), General American asserts that fiduciary status is related to the plan documents. ERISA not only requires that the allocation of fiduciary responsibility be set forth in the plan in writing, but it forbids a "named" fiduciary from delegating to anyone, other than an investment manager, the authority or discretion to manage or control plan assets.[2]

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[2] Petition at 10, 24; ERISA §§ 402(a)(1), (b)(2), 404(a)(1)(D), 405(c)(1), 29 U.S.C. §§ 1102(a)(1), (b)(2), 1104(a)(1)(D), 1105(c)(1).

ARGUMENT

THE NEW POINTS MADE IN THE BRIEF IN OPPOSITION ARE WITHOUT MERIT

The first point newly raised by IT Corp. involves a contractual provision in the ASA "*binding*" IT Corp. "with respect to past performance or completed action" by its agent, General American. (Opp., App. at A5-A6). IT Corp. contends that this provision somehow makes this case factually "unique" and confers fiduciary status on General American, thus distinguishing the case from the appellate decisions in seven other circuits relied on by General American. (Opp. at 4-5). IT Corp. is simply attempting to draw the Court's attention away from the fact that the Plan's eligibility requirements were laid down by IT Corp. in the Plan and that General American was required to follow those written requirements. The issue of fiduciary status under ERISA turns on who makes the framework of rules to govern plan administration as distinguished from who merely applies these existing rules on a case-by-case basis. IT Corp. made the eligibility rules for participation and benefits under the Plan and General American was required to follow them; accordingly, it did not exercise any "authority or control" over the Plan. Thus, whether a claim was paid or not is irrelevant to the issue of ERISA fiduciary status.

IT Corp.'s argument is misleading and untrue for two separate reasons. First, the Ninth Circuit's decision is not based on the ASA's contractual provision which, as shown below, is merely a recitation of a basic principle of agency law that is inherent in *every* case involving a contract-service provider. Instead, the court decided the case based on erroneous legal holdings that *any* claims-handling work in verifying eligibility for participation or benefits would involve plan interpretation and judgment and thus create fiduciary status, and that any claims agent automatically becomes an ERISA fiduciary whenever it handles plan money or has check-writing authority to pay benefits.

(Petition, App. at 5a to 12a). These holdings are in the sharpest of conflict with ERISA itself and the holdings of all other circuits to have considered these issues.

Second, the ASA's contractual provision merely acknowledges that the *general law of agency* applies to the relationship between the parties:

> . . . each individual administrative act, decision and interpretation by the Service Contractor [General American] (including any errors, clerical or otherwise) shall be binding upon the Client [IT Corp.] with respect to past performance or completed action. (Opp., App. at A5).

This contractual provision between IT Corp. and General American is nothing more than a recital that the law of agency makes the employer-principal bound by the acts of its agent within the scope of its authority or apparent authority. *See* section 140 of the *Restatement (Second) Agency*. IT Corp. was in no different a situation under agency law than had it used one of its own employees to determine eligibility for participation or benefits and to write payment checks. Further, it was in exactly the same position under agency law as the employers in all of the decisions from the other seven circuits which have held that the claims-processing and payment agent is not a fiduciary when it is merely required to follow a framework of rules established by the plan's administrator.

In short, General American's power as an agent to "bind" IT Corp. with respect to "past performance or completed action" was not the basis of the Ninth Circuit's decision; moreover, it is not novel or unique. To the contrary, it is inherent in the principal-agent relationships found in *all* of the decisions by the seven other circuits discussed in the petition at pages 15-20. Each of these decisions holds that ERISA's definition of fiduciary does *not* include agents of the employer or the plan who merely perform initial claims-handling and check-writing services under a framework of rules made by the plan's adminis-

trator. As explained by these decisions, it is not a sign of discretionary authority that the agent allegedly errs and authorizes or pays a claim that should not have been paid;[3] the employer still made the plan's framework of rules and the agent still has "an obligation to follow the written plan instrument."[4] Further, the decisions make clear that the claims agent would be a fiduciary only if it had the " 'ability to make policy decisions *outside* of a preexisting or separate framework of policies, practices and procedures,' "[5] or had the authority to conduct the ERISA review procedure for denied claims.[6]

In its second newly raised point, IT Corp. contends that a contract service-provider is a non-fiduciary only if it *recommends,* as distinguished from making, decisions in the course of plan administration. (Opp. at 6-15). This is not only erroneous but conflicts with the Department of Labor's regulations in 29 C.F.R. § 2509.75-8. The regulations provide an intentionally-broad "safe-harbor" from fiduciary status for claims-processing and payment agents who simply perform 11 wide categories of administrative and ministerial functions under a framework of rules established by the plan's administrator.[7] If IT

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[3] *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 21 (2d Cir. 1996); *Bromenn Healthcare v. Northwestern Nat. Life Ins. Co.*, 806 F.Supp. 799, 801, 804 (C.D. Ill. 1992).

[4] *Confer v. Custom Engineering Co.*, 952 F.2d 34, 39 (3d Cir. 1991).

[5] *Baker v. Big Star Division of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989) (emphasis added) (citation omitted).

[6] ERISA § 503, 29 U.S.C. § 1133.

[7] The decisions cited by IT Corp. undercut rather than support its position. For example, *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996), did not involve claims-processing or payment. The court held that ERISA did not preempt an attorney malpractice action against the plan's attorney who recommend the payment of lavish costs for a private jet and mansion. Significantly, it held that a non-fiduciary does *not* become one by acting negligently. *Santana v. Deluxe Corp.*, 920 F.Supp. 249, 254 (D.Mass. 1996),

Corp. were correct, the Department would have drafted the "safe-harbor" to provide that non-fiduciary functions were limited to "making *recommendations* as to eligibility for participation or benefits," etc. Instead, the regulations specify that large numbers of decision-making functions performed under rules made by the employer are purely administrative and non-fiduciary including "(1) *application* of rules determining eligibility for participation or benefits," "(6) *calculation* of benefits," and "(10) *processing* of claims." (emphasis added). As shown above, it was IT Corp. which established the eligibility rules for participation and benefits; it was IT Corp. which inserted those rules in the Plan document; and it was General American that was required to apply those rules. While the regulations mention "recommendations," they do so *only* as the final function in a list of 11 categories: "(11) Making recommendations to others for decisions with respect to plan administration."

In essence, IT Corp.'s new argument boils down to an absurdity. IT Corp. asserts that a party is a fiduciary if it has "final authority" over the *non-fiduciary* administrative and ministerial functions identified in the "safe-harbor." (Opp. at 6-15). According to IT Corp., "it is final authority that determines whether a function in question is a fiduciary function imposing a fiduciary duty." (*Id.* at 15). IT Corp. is certainly correct in stating that

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held that a third-party administrator was not a fiduciary where it merely processed and paid claims with plan funds based on a framework of rules established by the plan's administrator. The court's reference to "recommendations" dealt only with the agent's power in making "recommendations as to which services would make the plan most cost effective." *Haidle v. Chippenahm Hospital, Inc.*, 855 F.Supp. 127, 132 (E.D.Va. 1994), squarely held that "processing and payment of claims were administrative functions." Similarly, *Libby-Owens-Ford Co. v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1035 (6th Cir), *cert. denied*, 510 U.S. 819 (1993), held that the party who had the power to review the appeal of denied claims was an ERISA fiduciary; this was in accord with ERISA § 503, 29 U.S.C. § 1133.

this is the Ninth Circuit's position. The Department of Labor, however, has taken exactly the *opposite* position in the regulations, as do the seven other circuits which have considered the issue. In a key section overlooked by the Ninth Circuit and IT Corp., the regulations carefully explain that where the employer has established the plan's framework of rules, the 11 broad categories of claims-processing and payment functions are "purely ministerial functions" falling *outside* of the fiduciary functions described in ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A):

> Therefore, a person who performs purely minsterial functions such as the types described above . . . within a framework of . . . rules . . . made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan [and] does not exercise any authority or control respecting management or disposition of the assets of the plan . . . (App. to petition at 37a-38a).

In short, both common sense and the ERISA regulations dictate that having "final authority" over an administrative, ministerial, *non-fiduciary* function to be performed under the plan administrator's rules does *not* make a party a fiduciary. While both the Ninth Circuit and IT Corp. succumbed to this fallacy in logic, seven other circuits have wisely come to the correct conclusion.

In its third newly raised point which builds on the false premise contained in the second, IT Corp. asserts that because General American supposedly had "final" authority over initial claims-processing and payment to be performed under the Plan's rules, it was a fiduciary under section D-3 of the "safe-harbor" regulations. (Opp. at 6-9). This statement overlooks the fact that IT Corp. set the rules and inserted them in the Plan; and it is 180 degrees contrary to the position taken by the Department of Labor and the seven other circuits. In D-3 of the regulations, the *only* person identified as a "fiduciary" is

a *plan employee "designate[d]"* by the *plan* as having "the *final authority* to authorize or disallow benefit payments in cases where a *dispute exists as to the interpretation of plan provisions relating to eligibility for benefits.*" 29 C.F.R. § 2509.75-8 (D-3) (emphasis added) (App. to petition at 39a). As confirmed by the claims-handling and review regulations issued two years later,[8] these regulations discussing "final" authority are necessarily referring to the final ERISA review procedure for denied claims under § 503 of ERISA, 29 U.S.C. § 1133. The only dispute over benefit eligibility could be between the plan and its participants, and by statute there could be no "final authority" beyond the fiduciary review procedure under § 503. In this case, the claims review fiduciary with the requisite authority to review denied claims is IT Corp. (Petition at 1-2).

In its fourth newly raised point, IT Corp. contends that whether a contract-service provider is a non-fiduciary should depend on whether, in following the plan administrator's rules, it decides that a particular claim—perhaps one out of thousands processed each day—should be *denied* rather than paid. (Opp. at 17-19). Only if it pays the claim, IT Corp. asserts, is the party a fiduciary because then it is paying claims out of plan assets; if the claim is denied, it is not a fiduciary. (*Id.*)[9] IT Corp. also incorrectly suggests that the bonding regulations indicate that persons who "have control and/or authority over to whom the checks are made payable are fiduciaries."

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[8] 29 C.F.R. § 2560.503-1; petition at 12, 20-21.

[9] *LoPresti v. Terwillinger*, 126 F.3d 34 (2nd Cir. 1997), does not assist IT Corp.'s argument. The case did not involve benefit claims or the "safe-harbor" regulations. The court merely held that the president and major shareholder of an employer became an ERISA fiduciary when he commingled plan assets—moneys deducted from employees' paychecks—with the company's general assets, and then used the plan assets to pay the company's creditors.

(Id. at 17).[10] Under IT Corp.'s hypothesis, a party engaged in initial claims-processing and payment under rules established by the plan's administrator might be a fiduciary one moment when denying a claim; a non-fiduciary the next moment when approving a claim; and—like the Greek sea god Proteus—a half fiduciary, half non-fiduciary, the next moment when approving and denying a claim in part. If IT Corp. were correct, the Department of Labor would have drafted the "safe-harbor" regulations to provide that a party performing administrative and ministerial claims-processing and payment services under plan rules became a fiduciary if it *paid* a claim. Surely a fair warning would have surfaced in the regulations—a harbor buoy at least. IT Corp.'s anomalous construction of the "safe-harbor" converts it to a mine-field—every claims-processing and payment agent required to follow plan rules would be a fiduciary every day whenever it applied those rules and paid a claim.[11]

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[10] The bonding regulations say no such thing. IT Corp. has it exactly backwards. ERISA § 412(a) makes a clear-cut distinction between (1) "[e]very fiduciary of an employee benefit plan" and (2) "every person which handles funds or other property of such a plan" ("plan officials"); the regulations explain that the latter category of *non-fiduciaries includes* "any person with the *power to sign or endorse checks.*" (emphasis added.) 29 C.F.R. § 2580. 412-4 and -6. *Excluded* from the bonding requirements are those persons, referred to by IT Corp., who are "janitors" or who merely put checks into envelopes and mail them. The regulations explain that these people need *not* be bonded because the "checks . . . cannot be negotiated by the persons performing duties with respect to them." *Id.*

[11] Additionally, IT Corp. errs in stating that General American contends it can act with impunity under federal or state law, and that IT Corp. has no recourse against any entity. (Opp. at 19). As set forth in the petition, page 4, note 1, ERISA contains a "written plan instrument" rule which is one of ERISA's "core functional requirements." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). ERISA requires that plans be in writing, requires that their written terms be enforced, and provides suit

CONCLUSION

For the reasons set forth above and in the petition, petitioner urges the Court to grant certiorari in this case.

Respectfully submitted,

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to enforce the plan's terms. (*Id.*) The ASA contains cross-indemnity provisions (petition at 3, and App. at 27a), and is plainly a "contract, or other instrument under which the plan is . . . operated." ERISA § 104(a)(1), (b)(4). If IT Corp. truly thought that benefits were paid without its approval, it could have sued General American under ERISA as a nonfiduciary for equitable relief to enforce the cross-indemnity provisions which benefit both it and the Plan. Additionally, IT Corp.—not General American—could have sued the medical service providers for repayment. (Opp., App. at A6).